Module 3:
TRICARE Options

Module Objectives

After this module, you should be able to:

- List the differences between TRICARE Standard, Extra, and Prime
- Explain the TRICARE charges associated with the basic TRICARE options
- Identify TRICARE-authorized provider types
- Describe the TRICARE Travel Benefit for those with Special Compensation Determination

TRICARE

- When TRICARE was introduced in 1993, the following three basic options were implemented:
  - TRICARE Standard, a fee-for-service option
  - TRICARE Extra, a preferred provider option
  - TRICARE Prime, a managed care option
- There are certain costs and advantages associated with each option

TRICARE Standard

- TRICARE Standard is the basic entitlement under federal law
  - Coverage is automatic upon registration in the Defense Enrollment Eligibility Reporting System (DEERS)
- It is a fee-for-service option available to all non-active duty beneficiaries worldwide
- TRICARE Standard beneficiaries have the freedom to choose any
  TRICARE-authorized provider for TRICARE covered services
- Beneficiaries using TRICARE Standard pay higher out-of-pocket costs compared to the other basic TRICARE options
- An advantage of using the TRICARE Standard option is the freedom to choose from a larger provider pool
- Beneficiaries may be required to file their own claims

TRICARE Standard

Eligibility

- Active duty family members
- Retirees and their family members
- Survivors/Transitional Survivors
- Medal of Honor recipients and their families
- Family members of National Guard/Reserve members who are activated on federal orders for more than 30 consecutive days

Enrollment

- No enrollment required

Military Treatment Facility (MTF) Access

- Beneficiaries may receive care in an MTF on space-available basis only
- No charge for outpatient services
- Nominal fees apply for inpatient care

TRICARE Standard Costs

Status	Active Duty Family Member of E1 – E4	Active Duty Family Member of E5 and above	Retirees, retiree family members, Survivors, and eligible former spouses
Enrollment Fee	$0	$0	$0
Cost Shares	20% of TRICARE allowable charge	20% of TRICARE allowable charge	25% of TRICARE allowable charge
Deductibles	$50 per individual $100 per family	$150 per individual $300 per family	$150 per individual $300 per family
Catastrophic Cap	$1,000 per family per fiscal year	$1,000 per family per fiscal year	$3,000 per family per fiscal year

NOTE: The catastrophic cap is the maximum amount per fiscal year a beneficiary pays out-of-pocket for TRICARE-covered services or supplies.

TRICARE Extra

- TRICARE Extra is a preferred provider option available to all non-active duty standard beneficiaries in the continental U.S.
- When TRICARE Standard beneficiaries receive care from a provider who is a TRICARE network provider, they are using the TRICARE Extra option for that episode of care
- An advantage of using a TRICARE network provider is that the TRICARE Standard beneficiary receives a 5% discount off their cost share

Using TRICARE Extra (Example)

- Mrs. Green, a TRICARE Standard active duty family member, visits a non-network provider for a TRICARE-authorized service. She must pay a 20% cost share of the TRICARE allowable charge after the annual deductible is met.
- Mrs. Green, a TRICARE Standard active duty family member visits a provider in the TRICARE network for a TRICARE-authorized service. She must pay a 15% cost share (5% discount) of the negotiated rate after the annual deductible is met.

TRICARE Extra

Eligibility

- Active duty family members
- Survivors/Transitional Survivors
- Retirees and their family members
- Medal of Honor recipients and their families
- Family members of National Guard or Reserve members who are activated on federal orders for more than 30 consecutive days

Enrollment

- No enrollment is required

Military Treatment Facility Access

- May receive care in an MTF on a space-available basis only
- No charge for outpatient services
- Nominal fees apply for inpatient care

TRICARE Extra Costs

Status	Active Duty Family Member of E1 – E4	Active Duty Family Member of E5 and above	Retirees, retiree family members, Survivors, and eligible former spouses
Enrollment Fee	$0	$0	$0
Cost Shares	15% of fee negotiated by the regional contractor	15% of fee negotiated by the regional contractor	20% of fee negotiated by the regional contractor
Deductibles	$50 individual $100 family	$150 individual $300 family	$150 individual $300 family
Catastrophic Cap	$1,000 per family per fiscal year	$1,000 per family per fiscal year	$3,000 per family per fiscal year

NOTE: The catastrophic cap is the maximum amount per fiscal year a beneficiary pays out-of-pocket for TRICARE-covered services or supplies.

TRICARE Prime

- TRICARE Prime is a managed care option similar to a civilian health maintenance organization (HMO)
- TRICARE Prime enrollees get their routine and urgent medical care delivered and/or managed by their assigned Primary Care Manager (PCM)
- Prime enrollees may receive care at an MTF or from any TRICARE network provider
- An advantage of using the TRICARE Prime option is that it offers the lowest out-of-pocket costs when compared to the other basic TRICARE options

TRICARE Prime

Eligibility

- Active duty service members (only option available to them)
- Active duty family members
- Retirees and their family members under age 65
- Survivors under age 65/Transitional Survivors
- Certain former spouses under age 65
- Medal of Honor recipients and their family members under age 65
- Members of the National Guard/Reserve and their family members (when the sponsor is on federal active duty orders for more than 30 consecutive days)

Enrollment

- Required by eligible beneficiaries
- Three enrollment options:
  - Online via the Beneficiary Web Enrollment Web site at https://www.dmdc.osd.mil/appj/bwe/indexAction.do
  - Complete and mail the TRICARE Prime Enrollment Form to the regional contractor
  - Complete and submit the TRICARE Prime Enrollment Form to the TRICARE Service Center

TRICARE Prime

- When beneficiaries enroll in TRICARE Prime, they must select or be assigned a PCM
  - The PCM may be an MTF provider or a TRICARE network provider
- The PCM manages the beneficiary's medical care by:
  - Providing routine health care
  - Coordinating referrals for specialty care they cannot provide
  - Assisting with prior authorizations, when needed
  - Maintaining the beneficiary's medical health record

Seeking Care

- MTF (Direct Care)
  - Prime enrollees have first priority for access to primary care appointments
  - When MTF care is unavailable, they may be referred to a TRICARE network provider
- TRICARE Network Provider (Purchased Care)
  - Before seeking care, beneficiaries should ensure the provider is in the TRICARE network

TRICARE Prime

Enrollment Process

- Enrollment in TRICARE Prime is not automatic
- Beneficiaries must do the following to be enrolled in Prime:
  - Register in DEERS
  - Complete a Prime enrollment form
    - When the enrollment form is submitted on or before the 20th of the month, coverage begins on the first day of the next month
    - When the enrollment form is submitted after the 20th of the month, coverage begins on the first day of the second month
  - Pay an annual enrollment fee (when applicable)
    - No enrollment fee for ADSM or their eligible family members
    - Retirees pay an enrollment fee of $230/individual or $460/family
      - An initial three month payment must accompany enrollment form
      - Reenrollment is automatic

TRICARE Prime Costs

Status	Active Duty Family Member of E1–E4	Active Duty Family Member of E5 and up	Retiree, Retiree Family Members, Survivors, and eligible former spouses
Enrollment Fee	$0	$0	$230 individual $460 family
Co-Pays	$0	$0	$12 outpatient visit $17 mental health group session $20 ambulance $25 mental health individual $30 emergency room
Deductibles	$0	$0	$0
Catastrophic Cap	$1,000 per family per fiscal year	$1,000 per family per fiscal year	$3,000 per family per fiscal year

NOTE: The catastrophic cap is the maximum amount per fiscal year a beneficiary pays out-of-pocket for TRICARE-covered services or supplies.

TRICARE Prime POS Option

- The Point of Service option (POS) allows TRICARE Prime enrollees to receive non-emergency care from any TRICARE-authorized provider without requesting a referral from their PCM
- ADSMs cannot use the POS option
  - If they receive care without the proper authorization, TRICARE may deny the claim
- Prime enrollees incur POS charges for using the POS option

TRICARE Prime POS Option

Charges	Individual	Family
POS deductible per fiscal year	$300	$600
Cost shares for outpatient claims	50% of billed/allowed charge after POS deductible is met	
Cost shares for inpatient claims	50% of billed/allowed charge	
Point of Service deductible and cost share amounts are **NOT** creditable to the fiscal year catastrophic cap. The 50% cost share applies even after catastrophic cap for the fiscal year has been met.		

POS Exceptions:

- Emergency department services
- Preventive care services from a network provider
- Initial eight behavioral health outpatient visits from a network provider
- Primary OHI care (must have documentation that OHI processed the claim)
- Active duty service member care
- TRICARE Standard beneficiary care

TRICARE Prime

Access to Care Standards

- TRICARE Prime access standards establish the length of time it should take to see a provider based on the type of care being sought
- These access standards begin at the time of a beneficiary's call to or contact with the provider
- At times, appointments may not be available within the time frames listed below due to high demand for specialty care services; if the provider does not have appointments available within the access standards, the beneficiary can schedule the earliest available appointment with the provider or contact the regional contractor for assistance

	Urgent Care	Routine Care	Referred/ Specialty Care	Wellness/ Preventive Care
Appointment wait time	Within 24 hours (one day)	Within one week (7 days)	Within 4 weeks	Within 4 weeks
Drive Time	Within 30 minutes from home	Within 30 minutes from home	Within 60 minutes from home	Within 30 minutes from home
Wait time in office	**Not to exceed 30 minutes for non-emergency situations**			

Referrals

- A referral is the process of sending a patient to another professional provider for consultation or for a health care service that the referring provider believes is necessary, but is not prepared to provide or qualified to provide
- There are times when a beneficiary will need to see a specialist for a diagnosis or treatment that their PCM cannot provide
  - In this instance, the PCM will write a referral to access services from specialty providers and coordinate the referral request with the regional contractor, when necessary

Referrals

- If the beneficiary lives near an MTF and is referred for specialty care, inpatient admissions, or procedures requiring prior authorization, the regional contractor will attempt to coordinate care at the MTF first
  - This process is referred to as **the right of first refusal**; when the services are not available at any MTF, the care will be coordinated with a TRICARE network provider
- It is the beneficiary's responsibility to make sure that the referral is authorized by the regional contractor **BEFORE** they schedule the specialty appointment, or they may incur POS charges

Authorizations

There are two ways to get referrals authorized:

1) Beneficiaries get the referral from the PCM/provider and take it to the local TRICARE Service Center (TSC)

- The beneficiary may verify authorization by calling the regional contractor's toll-free number at a later date to confirm authorization or go back to the TSC for assistance
- The beneficiary may schedule the appointment, however the authorization is only good for 30 days, unless otherwise specified

2) The PCM/provider sends the referral via fax or electronically to the regional contractor, where it takes at least 48 hours for the referral to be entered into the authorization process

- The beneficiary may call the regional contractor's toll-free number to validate the authorization prior to making an appointment
- The regional contractor will send a letter to the beneficiary with the name(s) of network providers and the referral authorization

Authorizations

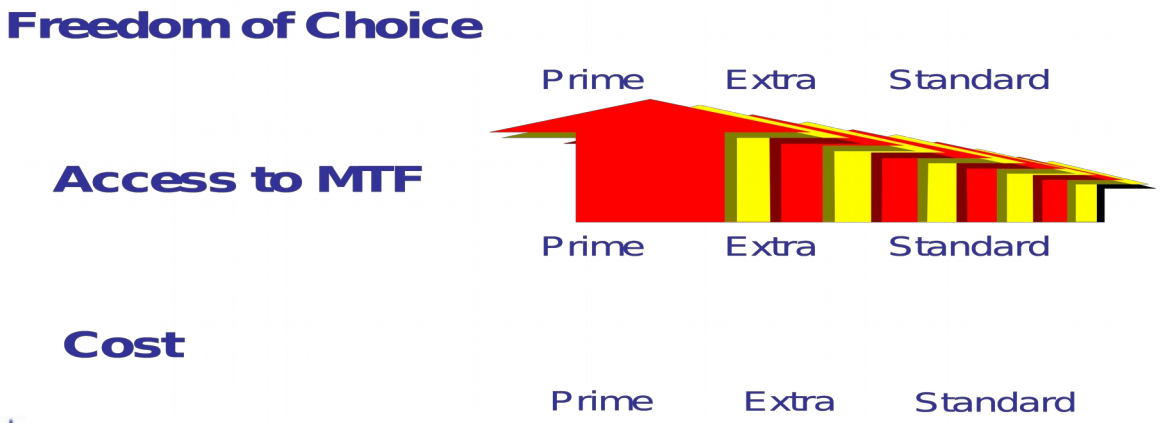
2) The PCM/provider sends the referral via fax or electronically to the regional contractor (continued)

- The beneficiary contacts the providers listed in the letter to confirm that the provider is in the network or is a TRICARE-authorized provider; if they are, the beneficiary can make the appointment
- Prior to the appointment, the beneficiary should find out from their PCM/provider what information pertaining to the referral (e.g., x-rays, labs) will be needed at the specialty care appointment
- Beneficiaries should also take the address and phone number of their PCM and regional contractor to their referral/specialty appointment

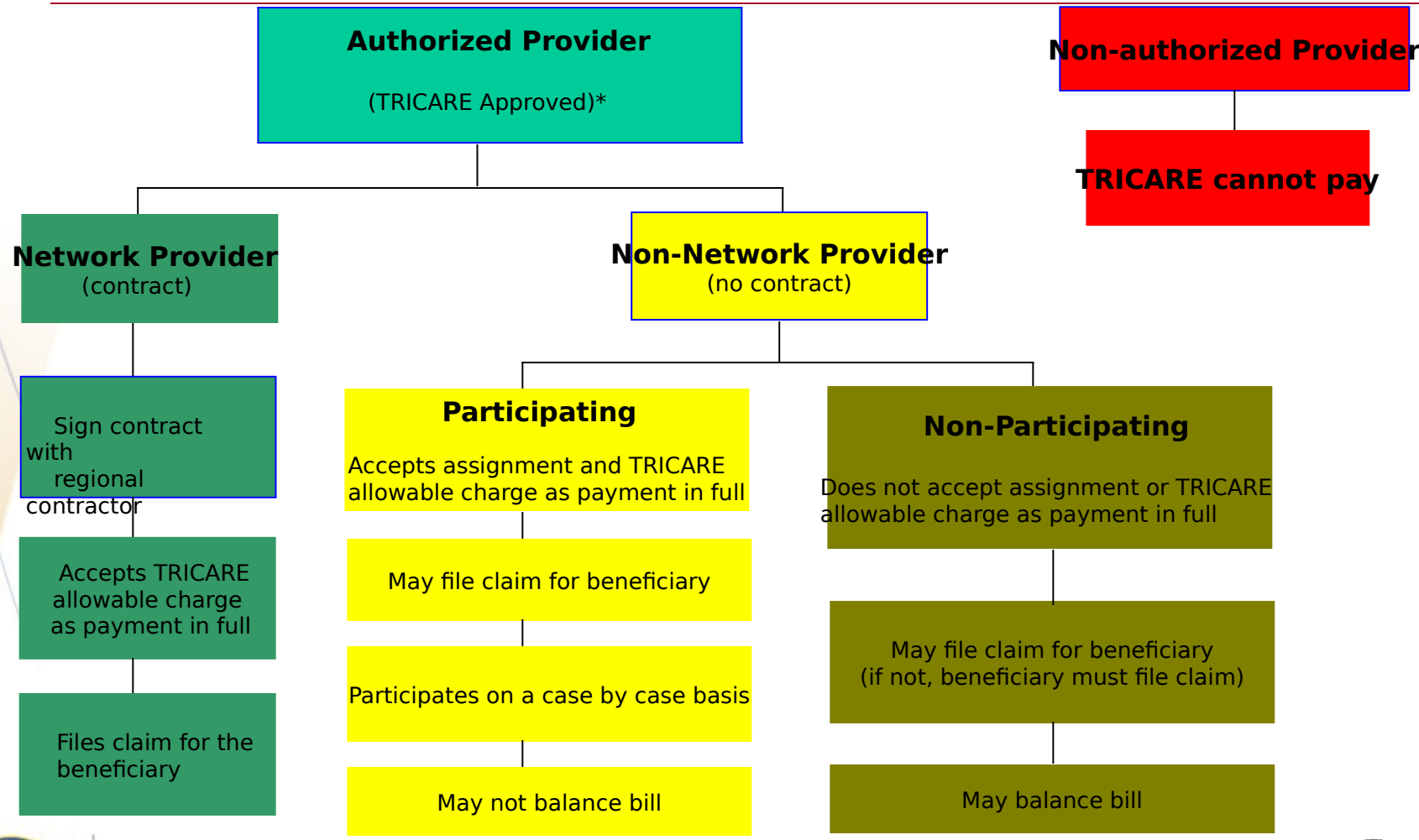
- Beneficiaries need to find out what measures the local MTF has in place to transport and manage medical health records/medical documents to their specialty care appointment; e.g., x-rays
- To avoid paying out-of-pocket or incurring POS charges, TRICARE Prime beneficiaries should make sure there is a referral/authorization in place

Choosing the Right Option

- Beneficiaries should understand some the key features of each of the basic TRICARE options in order to decide which is best for them
  - If freedom of choice from a larger provider pool is most important, TRICARE Standard may be the beneficiary's best option
  - If cost share discounts are most important, TRICARE Extra may be the TRICARE Standard beneficiary's best option
  - If cost savings and priority access to care within the MTF are most important, TRICARE Prime may be the beneficiary's best option



Types of Providers



*** NOTE: Medicare certified providers are considered TRICARE authorized per CFR 199.6 - Authorized Providers.**

Authorized Providers

- Authorized providers are individuals, institutions, organizations, or suppliers who are certified to provide benefits under TRICARE
- They must meet one or more of the following criteria:
  - Licensure by the state
  - Accreditation by a national organization
  - Meet other standards of the medical community
- Before getting care, beneficiaries should ask the provider if they are a TRICARE-authorized provider; if the provider is not, TRICARE cannot pay the bill
- Many Veterans Affairs (VA) health care facilities participate in TRICARE networks and provide primary care and specialty care for ADSMs and their family members
- Beneficiaries should contact the regional contractor to find out if a participating VA facility can provide care or if a separate Department of Defense VA agreement exists

Network and Non-Network Providers

- **Network providers** serve TRICARE beneficiaries through a contractual agreement with the regional contractor, which makes them a member of the TRICARE Prime network
- **Non-network providers** have no contractual agreement with the regional contractor; however, they may still serve TRICARE beneficiaries
- Two types of non-network providers:
  - **Participating, non-network provider**
    - Agrees to treat TRICARE beneficiaries on a case-by-case basis
    - Agrees to accept the TRICARE allowable charge as payment in full
  - **Non-participating, non-network provider**
    - Agrees to treat TRICARE beneficiaries on a case-by-case basis
    - Does not accept the TRICARE allowable charge as payment in full
    - May charge the beneficiary 15% more than the TRICARE allowable charge, which is referred to as balance billing

Prime Travel Benefit

- Must be a non-active duty TRICARE Prime enrollee
- Must have travel orders from TRICARE representative at MTF or from TRICARE Regional Office if the PCM is a TRICARE network provider
- Beneficiaries referred by PCM for services more than 100 miles from PCM may have “reasonable travel expenses” reimbursed
  - Costs of lodging, meals may also be reimbursed
  - Expenses must be itemized and receipts are required

TRICARE Travel Benefit for those with Special Compensation Determination

- This travel benefits allows for reimbursement of travel expenses to certain retirees
- For the travel benefit to apply, the beneficiary must:
  - Not be enrolled in TRICARE Prime or a designated provider (U.S. Family Health Plan); **and**
  - Be entitled to retired or retainer pay; **and**
  - Have been awarded Combat-Related Special Compensation (CRSC) and have the determination letter; **and**
  - Travel more than 100 miles from the member's residence to get the needed specialty care; **and**
  - Have their specialty care be related to the CRSC
- Retirees who qualify for special compensation should request the travel benefit reimbursement from their TRICARE Regional Office
- This travel benefit is not available overseas

Congratulations! You've Completed Module 3: TRICARE Options

You should now be able to:

- List the differences between TRICARE Standard, Extra, and Prime
- Explain the TRICARE charges associated with the basic TRICARE options
- Identify TRICARE-authorized provider types
- Describe the TRICARE Travel Benefit for those with Special Compensation Determination